DELAWARE DEPARTMENT OF INSURANCE

Data Submission Manual

2022 Affordability Standards Data Submission

18 **Del.C.** §§ 311, 334, 2503, 3342B & 3556A; 29 **Del.C.** Ch. 101

Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

May 11, 2022

Table of Contents

Contents

1. Introduction

18 **Del.C.** §§ 334 requires the Office of Value-Based Health Care Delivery to establish affordability standards, develop regulations on mandatory minimums for payment innovations, collect data and develop reports regarding carrier investments in health care and conduct other activities as necessary to support a robust system of primary care by January 1, 2026.

This data submission manual provides the format and contents of information needed to complete the Affordability Standards Data Submission template that will be used to assess compliance with requirements outlined in 18 **Del.C.** §§311, 2503, 3342B & 3556A regarding primary care spending as a percent of total cost of medical care, aggregate unit price growth for nonprofessional services and uptake and adoption of alternative payment models.

To meet this requirement, submitters shall provide a completed template, henceforth referred to as the "Affordability Standards Data Submission" or “Data Submission.” The Data Submission Template is available at the OVBHCD web page and shall be prepared in accordance with the instructions in this manual.

Please submit completed Affordability Standards Data Submissions and MLR Forms to the Director of the Office of Value-Based Health Care Delivery at OVBHCD@delaware.gov no later than June 15, 2022 for Individual and Small Group market segments and September 1, 2022 for the Large Group market segment. Please submit questions to OVBHCD@delaware.gov.

2. Required Submitters and Submission Instructions

Required Submitters: Per Title 18 of the Delaware Code, all commercial carriers that are required to file rates for health benefit plans as outlined in 18 **Del.C.** §§ 2503 shall also provide a completed Affordability Standards Data Submission Template.

Per 18 **Del.C.** §§ 2503, carriers with health benefit plans that cover more than 10,000 members across all fully-insured products will be evaluated for compliance as reported on worksheet "5a. APMA HCP-LAN."

Carriers with health benefit plans that cover less than 10,000 members across all fully-insured products will not be evaluated for compliance with requirements outlined in Section 8.2 of Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance but still must complete the worksheet.

Additional Documentation: Each carrier shall submit a copy (in PDF and Excel format) of its completed Centers for Medicare & Medicaid Services (CMS) Medical Loss Ratio (MLR) Annual Reporting Form for the 2021 MLR Reporting Year to the OVBHCD at OVBHCD@delaware.gov.

3. Population Specification

Carriers should report members enrolled in all fully-insured health benefit plans for the individual, small group and large group market segments.

Data for each market segment should be sent as a separate file.

Specific worksheets within the Affordability Standards Data Submission Template require data for only Delaware residents enrolled in these plans.

Please refer to the Data Submission Template Instructions below for detailed information on completion of the Data Submission.

4. Data Submission Template Instructions

The 2022 Affordability Standards Data Submission Template contains the following worksheets:

1. Overview

This worksheet requires carriers to provide contact information, attestations to the accuracy of the data provided and refers the carriers to this document for detailed instructions.

2. Medicare Parity Fee-For-Service

For CY 2021 and 2022, provide facility (if applicable) and non-facility payment amounts for fee-for-service codes with a fee included on the CMS Medicare Physician Fee Schedule and defined as primary care when paid to a Delaware primary care provider in a primary care place of service. The CPT codes for each of these services and the corresponding Medicare fee for Delaware is provided in the worksheet.

For each code listed in the worksheet, please provide the lowest contracted fee (Facility: 2021 Column D, 2022 Column O; Non-Facility: 2021 Column I, 2022 Column S).

For each code listed in the worksheet, please provide the lowest allowed amount (Facility: 2021 Column E; Non-Facility 2021 Column J). If the lowest contracted fee or the lowest allowed amount is lower than the Medicare fee, the subsequent column will indicate an "ERROR".

In the relevant column, provide an explanation as to why the fee is lower than the corresponding Medicare fee or leave blank. For each code where an ERROR is indicated, please complete worksheet "2a. Medicare Parity Fee-For-Service Underpayment".

2a. Medicare Parity Fee-For-Service Underpayment

For CY 2021, for any CPT code where the allowed amount is less than the Medicare fee, populate a row for each allowed amount lower than the Medicare fee (i.e., carriers shall add a row for each allowed amount for each CPT code). Therefore, there may be several rows for each CPT code, if there were multiple allowed amounts paid lower than the Medicare fee. Provide the total utilization paid at that allowed amount. In the relevant column, provide an explanation as to why the fee is lower than the corresponding Medicare fee or leave blank. Please provide this data for facility and non-facility payments. See example below.

2			Facility Price				
3	Code	Description	Medicare Fee for Delaware (Facility)	Allowed Amount	Utilization	Potential Underpayment	Business Rule or Other Explanation Re: Column D lower than Medicare
4	10060	Drainage Of Skin Abscess Simple	$106.18	$105.10	52	$56.16	
5	10060	Drainage Of Skin Abscess Simple	$106.18	$100.03	100	$615.00	

Note CMS changes fees for certain codes throughout a calendar year. Carriers will have one reporting cycle to comply with changes to Medicare fees and additional codes.

2b. Medicare Parity Non-Fee-For-Service

Using the instructions provided in the worksheet, describe the carrier's strategy and operations to comply with the requirements of Section 5.2 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance. Carrier applications for programs to be considered compliant with Section 5.2 should be sent to the Office at OVBHCD@delaware.gov prior to or during the rate filing application. Programs will be reviewed and carriers will receive a response from the Department regarding approval within 10 business days.

3. Primary Care Percent Spend (Delaware Attributed Members)

In this worksheet, carriers shall provide data only for Delaware residents who are attributed patients of contracted primary care providers, care teams and organizations participating in care transformation activities. As defined in Regulation 1322, care transformation activities may include a carrier primary care incentive program or National Committee for Quality Assurance Patient-Centered Medical Home certification program as detailed at NCQA.org. When developed, the Delaware Primary Care Model established by the Primary Care Reform Collaborative will also be an approved care transformation activity. Additional care transformation activities may be added via annual notice in future years. This document will be updated to reflect those additions.

This worksheet requests historical incurred and paid claims data and allowed claims data by service category. Indicate the market segment for this worksheet in Cell C1. Complete a separate worksheet for each market segment.

All claims data should be adjusted for IBNR. The difference between incurred and paid claims, adjusted for IBNR, and allowed claims should be equal to member cost sharing.

Unless otherwise noted in Section 5. "Definitions" on page 12, the service category definitions should align with those reported within the CMS' Center for Consumer Information and Insurance Oversight (CCIIO) in the Unified Rate Review Template (Federal URRT) instructions which may be viewed at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2021-URR-Instructions.pdf.

Guidance for Reporting Facility Fees Associated with Primary Care: In Worksheets 3 and 3a, report dollars associated with facility fees on Line 30 titled: Primary Care (Facility). Dollars associated with the professional fee should be reported on Line 29 titled: Primary Care (Professional). If the dollars cannot be unbundled, report the total on Line 29. If facility fees associated with primary care cannot be quantified state this on Worksheet 6: Notes. If

the carrier does not reimburse facility fees for primary care services, please state this on Worksheet 6: Notes.

Example scenarios: In its review of data from the Delaware Health Information Network, the Office found some carriers were reimbursing facility fees for certain primary care services. The three most common scenarios below may assist submitters in identifying when facility fees have been reimbursed for primary care services:

- Scenario 1: Two separate claims for the same person on the same day. One claim line has type of bill = 131 and procedure code = G0463. The other claim line has a place of service = 19 or 22 and an office visit procedure code (99202, 99203, 99214, 99215).
- Scenario 2: Two separate claims for the same person on the same day. One claim line has type of bill = 131. The other claim line has a place of service = 19 or 22. Both claims have an office visit procedure code (99202, 99203, 99214, 99215).
- Scenario 3: One claim line which has type of bill = 131. Claims have an office visit procedure code (99202, 99203, 99214, 99215…) and revenue code = 510 or the claim has a procedure code = G0663.

Once identified, carriers shall report all payments associated with the facility fees paid for primary care services in Worksheets 3 and 3a for their respective populations.

Risk Settlements Reporting: Risk Settlement payments include payments for shared savings and other total cost of care accountability programs. Risk settlement payments DO NOT include other types of non-fee-for-service payments. Please contact the OVBHCD with any questions regarding this distinction.

Risk settlement payments should be reported as a net of provider shared savings and provider losses, if any occurred. Carriers may allocate up to 8.5% of their total risk settlement payments to “Risk Settlements (Net) to Support Primary Care Services” without supplying documentation from providers. If the carrier wishes to classify more than 8.5% of its risk settlement dollars as Risk Settlement Payments to Support Primary Care Services, the carrier will need to supply attestations from all provider organizations receiving payments allocated to this category. The attestation should include a confirmation that the dollars were used to support primary care activities and a description of how such dollars were used. As required, please submit attestations with the completed Data Submission.

Primary Care Spending Definitions

Primary Care (Total) is defined as the sum of the total of Primary Care (Professional, Claims), Primary Care (Facility, Claims) and Primary Care (Non-Claims).

Please see Appendices A, B, and C in the Data Submission Template for relevant definitions. Appendix A identifies the CPT codes that are defined as primary care services, Appendix B

identifies the provider taxonomy codes considered primary care providers, and Appendix C identifies place of service taxonomy codes that are considered primary care places of service. Services defined as primary care must be performed by a primary care provider at a primary care place of service to qualify as primary care investment.

The Primary Care (Non-Claims) category is the sum of five subcategories:

- "Non-Claims: Primary Care Incentive Programs"
- "Non-Claims: Primary Care Capitation"
- "Non-Claims: Risk Settlements (Net) to Support Primary Care Services"
- "Non-Claims: Primary Care, Care Management"
- "Non-Claims: Primary Care, Other"

To be in compliance with Section 6 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance, the Carrier's total primary care spending (Line 62, PC %Spend DE Attributed Members) must be equal to 8.5% of medical TME for these same members (Line 27, PC %Spend DE Attributed Members).

3a. Primary Care Percent Spend All Members

Carriers shall provide data for all members enrolled in Delaware-sitused plans, including those who live outside of Delaware and regardless of whether they are attributed to a provider. This population should mirror the population used to complete the Federal URRT, unless otherwise noted in Section 5. "Definitions" on page 12.

Report historical incurred and paid claims data and allowed claims data by service category. All claims data should be adjusted for IBNR. The difference between incurred and paid claims and allowed claims should be member cost sharing. Please indicate the market segment reported in cell C1.

The service categories should align with the categories reported within the Federal URRT. The allowed claims dollars should match what is reported in the URRT. If they do not, please provide an explanation on Worksheet 6: Notes.

3b. Primary Care Providers in Care Transformation Programs

This worksheet requests information on the participation of primary care providers in care transformation programs. Provide details on the capabilities associated with advanced primary care and details on payment innovation programs. The Data Submission Template provides, by way of example, primary care capabilities as discussed by the Delaware Primary Care Reform Collaborative, carriers shall include any additional primary care capabilities based on their contracts with providers.

4. Measurement of Non-Professional Price Growth

This worksheet requires historical and projected price and utilization and mix trends by the same service categories as reported in Worksheets 3 and 3a for all members enrolled in Delaware-sitused plans.

- The utilization trend should include service mix and provider mix.
- The price trend should reflect the actual price change of services.
- All trends reported should be on an allowed basis.
- The worksheet includes a check to ensure that the overall PMPM trends are within +/-0.5% of the PMPM trends reported in the Primary Care Percent Spend worksheet. If the reported trends do not meet the check, explain on Worksheet 6: Notes.
- This worksheet also requests prospective trend assumptions which should align with the insurer's expectations and pricing trend assumptions. For simplicity this is aligned this request with URRT.
- Price trend refers to the anticipated change in negotiated rates. All other components of trend should be included in the utilization and mix trends column. If the price trend is different from what is typically reported in the URRT's "Cost Trend" column, state this on Worksheet 6: Notes.
- Report the trend percentage, not the trend factor in this worksheet.

Compliance with Section 7 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance dictates that the Carrier’s price trend for Inpatient Hospital, Outpatient Hospital and Other Medical services must not exceed 3.7% in CY 2023.

This reflects requirements in Section 2.7 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance, which is the average Core CPI for the average of the previous three years of United States Department of Labor data ending January 31st of 2022, plus 1% as required by statute.

5. Alternative Payment Model Adoption Fixed Payment Methodology

Please describe the carrier’s plan to meet the requirements of Section 8.1 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance in the 2023 Data Submission.

5a. Alternative Payment Model Adoption HCP-LAN

This worksheet reports total historical allowed (including member cost sharing) medical expenses for all of the carrier's fully-insured, Delaware-sitused plans for the past three years and projected for the next two years. Historical medical expenses, including IBNR, should be reported in the year incurred. Due to the nature of these contracts, the carrier may include members covered on a self-insured basis, if preferred. Carriers shall provide information on the shared savings and loss percentages and savings and losses caps in contracts categorized as Health Care Payment Learning and Action Network (HCP-LAN) Category 3-A and 3-B, as defined in section 5 of this manual. Please complete rows 42-47 for each shared

savings contract in LAN Category 3-A and 3-B in each year and ensure that the minimum percentage splits for savings and losses follow requirements outlined in Section 8.2 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

In addition, the carrier is required to categorize medical expense into the categories listed below.

- For LAN Categories 2A through 4C, report the total dollars, including the underlying payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.
- For APMs in which the provider is responsible for the total cost of a member or beneficiary's health care, include the total costs incurred by the member or beneficiary covered under that plan.
- Not all carriers will report dollars under each subcategory. In most cases, carriers are experimenting with different payment methods that span across Categories 2 through 4.
- Carriers should report the alternative payment models in effect for the appropriate calendar year. ***Please report ALL medical expenses that are under the alternative payment arrangement, not just the risk settlement, bonus or savings or other non-claims payments***.

When a contractual arrangement begins during the reporting year, the carrier is expected to report the expenditures in the appropriate LAN Category. For example, if the carrier enters into a shared savings contract effective August 1, 2019, (and the reporting period is CY 2019) the carrier should report the total dollars (includes FFS payments and bonus/savings incentives) paid to that provider under the shared savings arrangement from August 1, 2019 – December 31, 2019, whereas it would report dollars paid to the provider between January 1, 2019 and July 30, 2019 under LAN Category 1.

Given the timing of the data request and the need project future years, some carriers may not have access to complete or final data. If complete or final information for the calendar year is not complete, provide an estimate and state the basis for the estimate on Worksheet 6: Notes. Similarly, if the bonus or savings amounts are not reconciled by the time of data collection, estimate the bonus or savings payment amount (if any) and state the basis for this estimate on Worksheet 6: Notes.

If the carrier does not directly manage members and dollars in an APM, neither the lives nor dollars should be counted. The carrier that manages those lives should count those members and dollars if it is participating in the data collection effort.

Though all carriers must report this data, only carriers with more than 10,000 Delaware residents enrolled across all fully-insured products are required to meet the statutory and regulatory requirements.

Compliance with the requirement that 50% of total cost of care be tied to an alternative payment model contract that qualifies as a Health Care Payment Learning and Action Network (HCP-LAN) Category 3 will be assessed by summing the percentages in HCP-LAN 3-A and HCP-LAN 3B. Compliance with the requirement that 25% of total cost of care be tied to an alternative payment model contract that qualifies as a Health Care Payment Learning and Action Network (HCP-LAN) Category 3B will be assessed using the percentage reported as 3B. Compliance only requires meeting these thresholds for Delaware residents.

6. Notes

Please provide notes to the questions asked in this worksheet and indicated in prior worksheets. In addition, please provide any additional information that may be necessary to determine compliance with Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

7. Appendix A – Primary Care CPT Codes

This worksheet includes the list of CPT codes defining primary care. Please use this list of codes to determine primary care investment.

8. Appendix B – Primary Care Provider Taxonomies

This worksheet includes the list of primary care provider taxonomy codes associated with the delivery of primary care services. Please only report primary care spending for services provided by these provider taxonomies.

9. Appendix C – Primary Care Place of Service

This worksheet includes the list of place of service codes where primary care services are provided. Please only report primary care spending for services provided by provider taxonomies at these places of service.

5. Definitions

1. **"Allowed Amount" –** The total payment made for a service to the provider by the health insurance carrier and the member cost share, including the deductible, copayment or coinsurance.
2. **"Contracted Fee"** – The fee for a service as outlined in contracts between a health insurance carrier and healthcare provider.
3. **"Facility"** means a place where healthcare is delivered, including by way of example only, a hospital, outpatient clinic or nursing home.
4. **"Health benefit plan"** has the meaning set forth in 18 **Del.C.** §§ 3342A(a)(3)a. and 3559(a)(3)a.
5. **"Inpatient hospital services"** means non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.
6. **"LAN Category 1 - Fee For Service"** - Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.
7. **"LAN Category 2A - Fee for Service Linked to Quality & Value"** - Foundational Payments for Infrastructure & Operations: Payments placed into Category 2A involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.
8. **"LAN Category 2B - Fee for Service Linked to Quality & Value"** - Pay for Reporting: Payments placed into Category 2B provide positive or negative incentives to report quality data to the health plan and/or to the public.
9. **"LAN Category 2C - Fee for Service Linked to Quality & Value"** - Pay for Performance: Payments are placed into Category 2C if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. Note that a contract with pay-for-performance that affects the future fee-for-service base payment would be categorized in Category 2C.
10. **"LAN Category 3A - APMs Built on Fee-For-Service Architecture**" - APMs with Shared Savings: In Category 3A, providers have the opportunity to share in a portion of the

savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.

11. **"LAN Category 3B - APMs Built on Fee-For-Service Architecture"** - APMs with Shared Savings and Downside Risk: In Category 3B, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.
12. **"LAN Category 4A - Population-Based Payment"** - Condition-Specific Population-Based Payment: Category 4A includes bundled payments for the comprehensive treatment of specific conditions.
13. **"LAN Category 4B - Population-Based Payment"** - Comprehensive Population-Based Payment: Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.
14. **"LAN Category 4C - Population-Based Payment"** - Integrated Finance & Delivery System: Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization.
15. **"Nonprofessional services**" means services categorized as such as part of development of the Unified Rate Review Template as inpatient hospital, outpatient hospital, and other medical services.
16. **"Non-Claims: Primary Care Incentive Programs"** - All payments made to contracted primary care providers and their health care teams for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay for performance payments, performance bonuses and EMR/HIT adoption incentive payment.
17. **"Non-Claims: Incentive Programs, for Services Other Than Primary Care"** - All payments

made for achievement in specific predefined goals for quality, cost reduction or infrastructure development that are not accounted for in **Non-Claims: Primary Care Incentive Programs"**. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

18. **"Non-Claims: Primary Care Capitation"** - All payments made to contracted primary care providers and their health care teams made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, and can be separately reported as **"Non-Claims: Incentive Program"**. These payments are typically made monthly for the care of assign beneficiaries.
19. **"Non-Claims Capitation, for services other than primary care"** - All payments made not on the basis of claims (i.e., capitated amount) not accounted for in **"Non-Claims: Primary Care Capitation"**. Amounts reported as capitation should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.
20. **"Non-Claims: Risk Settlements to Support Primary Care Services"** - All payments made to primary care providers and their care teams as a reconciliation of shared savings and/or loss payments used to implement total cost of care accountability programs. Amounts reported as "risk settlement" should not include any incentive or performance bonuses paid separately, that could be separately reported as "**Non-Claims: Primary Care Incentive Program".**
21. **"Non-Claims: Risk Settlements to Services Other than Primary Care" -** All payments made to providers as a reconciliation of shared savings and/or loss payments used to implement total cost of care accountability programs and not accounted for in **"Non-Claims: Risk Settlements to Support Primary Care Services".** Amounts reported as "risk settlement" should not include any incentive or performance bonuses paid separately, that could be separately reported as "**Non-Claims: Incentive Program".**
22. **"Non-Claims: Primary Care, Care Management"** - All payments made to primary care providers and their care teams for providing care management, utilization review and discharge planning.
23. **"Non-Claims: Care Management other than for primary care"** - All payments made to for providing care management, utilization review and discharge planning that are not accounted for in **"Non-Claims: Primary Care, Care Management".**
24. **"Non-Claims: Primary Care, Other" -** All other capitation and non-claims payments to support primary care that do not fit in the above categories, such as including by way of example only community health teams, integrated behavioral health, and coordination of social services and health care. For CY 2020, this may also include supportive funds

made to primary care providers and their care teams to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; grants and other insurer administrative expenditures (including corporate allocations) should not be included unless the carrier has received explicit approval from the OVBHCD. Insurer administrative expenditures approved by the OVBHCD will be considered indirect primary care spending and shall not exceed 1% of total medical expense excluding pharmacy spending.

25. **"Non-Claims: Other" -** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere including under **"Non-Claims: Primary Care, Other".** This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.
26. **"Other medical services"** means non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from professional services and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions. "Outpatient hospital services" means non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.
27. **"Population-based payment"** means an arrangement in which a provider entity accepts responsibility for delivering covered services to a group of patients for a predetermined payment amount.
28. **"Primary Care First" or "PCF"** means the CMS five-year alternative payment model program established under the authority of Section 1115A of the Social Security Act that aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.
29. **"Professional services"** includes services categorized as such as part of development of the Unified Rate Review Template including primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the

facility fee component of hospital-based services.

30. **“Total cost of medical care”** means the sum of all payments by carriers, including fee-for-service and non-fee-for-service payments, for medical services paid to healthcare providers on behalf of patients and excludes spending on pharmaceutical products categorized as “pharmacy” as part of development of the Unified Rate Review Template.
31. **“Unified Rate Review Template**” means a form that summarizes the data used to determine rate increases for the entire single risk pool. The form and instructions to support its completion are released each year by CMS’ Center for Consumer Information and Insurance Oversight (CCIIO).
32. **“Year”** means the calendar year in which rates are filed with the Department and applicable to the following plan year.